Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2606AGZ	A. BUILDING _____ B. WING _____	C 02/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF BOULDER CITY	1401 MEDICAL PARK DR BOULDER CITY, NV 89005 Dm 3/8/10

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an complaint investigation conducted on your facility from 1/21/10 to 2/2/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 84 Total Residential Beds: 53 beds for Elderly or Disabled Category I Residents and 31 beds which provides care to persons with Alzheimer's Disease Category II Residents. Complaint #NV00024169 was substantiated. See TAG Y0850. The following deficiencies were identified:	Y 000	Acceptable POC	
Y 850 SS=D	449.274(1)(a) Medical Care of Resident NAC 449.274 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of the illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the	Y 850		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/3/10

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Y 850	Continued From page 1 resident is the resident's physician is not available. This Regulation is not met as evidenced by: Based on record review and interview on 2/1/10 & 2/2/10, the facility failed to ensure that 1 of 56 residents received services of a licensed physician following an injury in a timely manner (Resident #1). Severity: 2 Scope: 1	Y 850	Y850 a)a policy is in place for on-call RN to make all necessary arrangements to secure the services of a licensed physician to treat the resident if the resident's physician is not available. The Administrator will monitor for compliance. (Attachment #1) b)Resident Protection training was completed 3/3/10 for all managers. (Attachment #2 pg1-9) c)Resident Protection training for all employees will be completed by 3/31/10. New employees will receive Resident Protection training at orientation. The Administrator will monitor for compliance.	